Root Cause Analysis (RCA)
&
DoD Documentation Form

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Root Cause Analysis

- A tool used to systematically and objectively identify process and system “glitches” resulting in basic and causal factors that underlie variation in performance.

Leadership Support

- Critical to Staff Participation
  - ✓ Ensure SAC score for all events
    - SAC 3 events require RCA
  - ✓ Charter RCA Team
  - ✓ Clearly Identify Team Timeline
  - ✓ Involvement and Team Support
    - IM/IT
    - Incentives to encourage participation
- THANK/Recognize the Reporter(s)

Impact of Leadership

- Leadership sets the tone for the facility's culture of safety
- Leadership's active involvement reinforces PS as a priority
- Leadership's involvement ensures compliance with action plan implementation & evaluation of effectiveness

Preparation

- **PSM Completes RCA Form # 1-13**
  - ✓ Demographics
  - ✓ Previous event & corrective actions
  - ✓ Description of event
  - ✓ Immediate Actions Taken
- **Ensures Team Charter Executed**
  - ✓ What disciplines are needed?
  - ✓ Service/Dept Chief buy-in & awareness
  - ✓ What individuals would be best suited for team?

RCA Team

- **RCA Facilitator** - Process Expert (TapRooT)
- **Team Leader** - Content Expert (in charge)
- **Team Members** (3-5)
  - ✓ All levels of personnel closest to event
  - ✓ Someone w/ decision making authority
  - ✓ Process owners
  - ✓ Personnel directly involved may NOT be appropriate

Getting Started 1

- Team Introductions
- Clarify Roles & Responsibilities
- Establish Ground Rules
- Communication Strategies
- Meeting Schedules
- Team Assignments
  - ✓ Ensure All Time Spent Documented

Getting Started 2

- **Meeting Environment**
- **Room set up**
- **Equipment set up**
  - ✓ Laptop computer/LCD (TapRooT Program)
  - ✓ Easels/post-it notes for diagrams
  - ✓ Parking lot issues

RCA Process
(Meeting 1)

- **Review Provided Information** (RCA Form #1-13)
- **Review 'Triage' Questions Booklet**
  - ✓Identify Relevant Processes Associated w/ Event
    - Staff Training/Competency
    - Patient Assessment
    - Equipment
    - Lack of Information
    - Communication
    - Rules/Policies/Procedures
    - Barriers
    - Personnel/Personal Issues
  - ✓Identify Areas/Service(s) Impacted

RCA Process
(Meeting 1)

- **Document Initial Understanding of Event** (RCA Form #14)
  - ✓ Develop SnapCharT (Flow Diagram)
    - Sequence of events
    - Actual process as documented
  - ✓ Use computerized program during team meetings

RCA Process
(Meeting 1)

- **Identify Information to Review**
  - ✓ Policies, procedures, reports, regulations, medical records, committee minutes, etc.
- **Identify Personnel to Interview**
- **Assign Literature Search**
  - ✓ Literature reviews used to arrive at Root Cause/Contributing Factors, current standards of practice and/or identification of effective actions
- **Document RCA Form** (Sections 15-17)
  - ✓ Identify Responsible Team Member
  - ✓ Timeline for Acquiring Information

RCA Process
(Meeting 2)

- **Review Team Assignments & Information Obtained**
- **Document Final Understanding of Events** (RCA Form # 18)
  - Diagram Final Flow Diagram (2nd Snap CharT)

RCA Process
(Meeting 2)

- **Identify & Analyze Causal Factors using Root Cause Tree**
  - ✓ Analyze one causal factor at a time
  - ✓ Examine all basic cause categories that apply to the event
    - Use TapRooT Root Cause Tree Dictionary
  - ✓ Document on RCA Form Table # 19

RCA Process
(Meeting 3)

- **Root Cause/Contributing Factors Table**
  - ✓ Organize list of root causes (RCA Form # 19)
  - ✓ Verify completeness using JC “minimum scope” document (see handout)
  - ✓ Prioritize Contributing Factors/Root Causes
    - Patient Safety
    - Applicable to Multiple Sites
    - May be Resource Driven
    - Retain Explanations for ‘Can’t Do’ Items

RCA Process
(Meeting 4)

- **Evaluate Corrective Actions using Corrective Actions Helper** (SMARTER)
  - ✓ **S**pecific; **M**easurable; **A**ccountable;
  - ✓ **R**easonable; **T**imely; Reviewed
- **Document Corrective Actions** (RCA Form # 23)
  - ✓ Identify corrective action for each identified root cause or contributing factor
  - ✓ Prioritize Actions
    - Does action eliminates, controls, accept cause?
  - ✓ Identify Outcome Measure
  - ✓ Identify Time-line/Follow-up Dates

RCA Process (Meeting 5)

- Identify How Best to Communicate Findings (RCA Form # 22)
  - ✓ Identify & Document
    - What was learned
    - Who needs to know
    - Best way to share information/action plan
- Use as preparation for Team Action Plan (RCA Form # 23)

Measurement Strategy

- Set Reasonable/Attainable Goals
  - ✓ Actions must be measurable
  - ✓ Consider who/how/what/when action will be measured
  - ✓ Designate reporting/oversight responsibility
- Working Document - NOT just for JCAHO!

Measurement Suggestions

- **Rapid Cycle Improvement Process** (PDSA)
  - ✓ Ensure publication of new/updated SOPs
  - ✓ Pilot Test new clinical process prior to full implementation
  - ✓ Verbal verification of staff knowledge of new policies/procedures/protocols
    - Spot Checks - Ask 3 staff/shift; provide them w/ ‘sticker’ reward to ensure different staff participate
    - Weekly update to staff

Implement Improvements

- **RCA Action Plan Table** (RCA Form # 23)
  - ✓ Assigns who & when
  - ✓ Funding concerns are raised as priority to Command
  - ✓ Team consensus & Department's knowledge
- **Check Implementation Progress**
  - ✓ PS Manager follow-up per timeline
  - ✓ Timeframe 6 months & 1 year
  - ✓ Closure at 1 year

Act to Maintain

- **Communicate findings to reporter**

  (RCA Form # 21)
- **Use SE/Near Miss data as learning experience for MTF**
- **Incorporate new policies/procedures in departments**
- **Incorporate lessons learned into hospital/unit orientation**

Putting it All Together

- Benefits to using a “Planned” Root Cause Analysis Process
  - ✓ Avoids crisis mode operations
  - ✓ Provides focused, systematic approach to problem solving
  - ✓ Reduces rework
  - ✓ Appreciate what can be done in 45 days

Roll-Up

- **3 - 5 Team Meetings** (2 hr)
  - ✓ Meeting 1 – Team Process/SnapCharT
  - ✓ Meeting 2 – Final SnapCharT/Root Cause Tree
  - ✓ Meeting 3 – Corrective Action Helper (SMARTER)/ Contributing Factor Table
  - ✓ Meeting 4 - Action Plan/Metrics
  - ✓ Meeting 5 - Communication/Feedback Plan
- **Team Leader/Facilitator**
  - ✓ May Need to Meet Off-line
  - ✓ Monitor Action Plan Progress/Effectiveness

Resources

- **SE/Near Miss Management**
  - ✓ JC Sentinel Event Alerts
  - ✓ JC Sentinel Event Hotline (630) 792-3700
  - ✓ JCAHO - www.jcaho.org
- **Team Training**
  - ✓ Scholtes, Joiner & Streibel, The TEAM Handbook, 2nd Edition, 1996.

Conclusion

Make the Safest Way the Best Way!

Thank you!

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